Section A: This section must be completed for all Authorizations

Patient Name:	**Date of Birth:**	**Patient's Phone:**	**Last 4 digit SSN (optional)**

Provider's Name:
☐ Methodist/Methodist Children's Hospital
☐ Methodist Specialty and Transplant Hospital
☐ Metropolitan Methodist Hospital
☐ Methodist Texsan Hospital
☐ Methodist Stone Oak Hospital
☐ Northeast Methodist Hospital
☐ Methodist Ambulatory Surgical Hospital
☐ Methodist Hospital South

Recipient's Name: XL Record Service

Address: PO Box 153736

Recipients Phone:	**Recipient's Fax:**	
City:	**State:**	**Zip:**
Lufkin	TX	75915

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.*, paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (*e.g.*, virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**
Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed.

Purpose of disclosure: Litigation

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative/Cath reports		☐ Labor/delivery summary	
☐ Discharge summary		☐ Progress Notes		☐ Discharge instructions	
☐ History and physical		☐ EEG/EKG/Stress test		☐ Abstract (pertinent sections)	
☐ Physician orders		☐ Radiology reports		☐ Itemized bill:	
☐ Consultation reports		☐ Nursing information		☐ UB-04:	
☐ Lab results		☐ Transfer forms		☐ Dates of Service List:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No
If yes, describe:
May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Fax back to: **Methodist Hospital at (210) 581-4921, Methodist Specialty and Transplant at (210) 575-8312 Metropolitan Hospital at (210) 757-2160, Northeast Methodist at (210) 510-7270, MASH (210) 575-5193, Stone Oak Methodist (210) 638-3884, Texsan Methodist (210) 510-7703, Methodist Hospital South at (830) 769-5249.**

ROI